U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 31 May 2007

Case No.: 2006-BLA-05298

In the Matter of:

J.L.,

Claimant,

v.

SOUTHERN HILLS MINING CO., INC.,

Employer,

and,

KENTUCKY COAL PRODUCERS
SELF-INSURANCE FUND,

Carrier,

and,

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Party-In-Interest.

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act (BLBA), 30 U.S.C. § 901 et seq. The BLBA and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The BLBA and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. §

902(b); 20 CFR § 718.201 (2005). In this case, the Claimant[1] alleges that he totally disabled by pneumoconiosis.

This claim was referred to the Office of Administrative Law Judges on January 3, 2006, and a hearing was held in Hazard, Kentucky, on January 16, 2007. Both parties were present and afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2005). The Director did not have a representative present. At the hearing, the Claimant was the only witness. Administrative Law Judge Exhibits 1 through 3, Director's Exhibits 1 through 35, Claimant's Exhibit 1, and Employer's Exhibit 1 were admitted into evidence without objection[2]. (TR 6 through 8) Post-hearing briefs were received from counsel and the record is now closed.

This case has been assigned to the undersigned Administrative Law Judge. The findings and conclusions which follow are based on a complete review of the record, argument of the parties, applicable statutory regulations and pertinent precedent.

PROCEDURAL HISTORY

The Claimant filed his current claim on January 28, 2005 (DX 2). The Director of the Office of Workers' Compensation Programs ("OWCP") issued a proposed Decision and Order denying benefits on October 12, 2005, on the grounds that the evidence did not show that the Claimant had pneumoconiosis, or that it was caused by coal mine work, or that it caused a breathing impairment of sufficient degree to establish total disability under the BLBA (DX 30). The Claimant filed appealed the determination on October 21, 2005 (DX 31). The claim was referred to the Office of Administrative Law Judges for hearing on January 3, 2006 (DX 33).

APPLICABLE STANDARDS

This claim was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations. For this reason, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2005). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, 718.204, and 725.103 (2005).

STIPULATIONS

At the hearing the following oral stipulations of fact were entered:[3]

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[1] After August 1, 2006, the Department of Labor policy requires the use of initials for the claimant's name in headings and use of a descriptive title in the decision. Accordingly, "Claimant" is used in this decision vice the proper name of the individual who is the subject of this decision.

[2] The following notations apply: ALJX – Administrative Law Judge exhibit; CX – Claimant exhibit; EX – Employer exhibit; TR – Transcript page of hearing transcript.

[3] TR 5

1. The claim was timely filed.

2. The Claimant was a miner under the BLBA while employed with Southern Hills Mining Company, Inc..

ISSUES

The issues remaining to be resolved are:[4]

1. How long did the Claimant work as a coal miner ?

2. Whether the Claimant has pneumoconiosis as defined by the BLBA and the regulations.

3. Whether the Claimant has pneumoconiosis arising out of coal mine employment.

4. Whether the Claimant is totally disabled due to pneumoconiosis.

5. Whether the named Employer is the Responsible Operator.

DISCUSSION OF RELEVANT EVIDENCE

I. Contention of the Parties:

Position of Claimant:

Claimant's counsel submits that the Claimant suffers from pneumoconiosis based on the medical examination and reports of Dr. Rasmussen. He also submits that the Claimant has worked as a coal miner for 18 years and is entitled to the presumption that the pneumoconiosis arose out of coal mine employment.

Claimant's counsel argues that the Claimant's breathing impairment prohibits him from returning to his usual coal mine employment due to the dust exposure and has adversely affected his ability to perform any comparable gainful employment.

Position of Respondent:

Respondent's counsel submits that the Claimant last worked in and around the coal mining industry on January 3, 2004, as a coal mine inspector, with the last 10 years of his 16 year-employment with the U.S. Bureau of Mines and Mine Safety and Health Administration (1988 to 2004) being as a specialist who took samples of dust and monitored noise levels. Prior to that period, he was an owner/operator of Southern Hills Mining Company, Inc. He notes that the District Director found 18 years of coal mine employment between 1978 and December 2003. Counsel argues that U.S. Government was the last employer to employ the Claimant in and

[4] TR 5

around coal mining employment such that the Respondent should not be liable for Claimant's respiratory condition.

Counsel also argues that the evidence of record fails to establish that the Claimant has either clinical or legal pneumoconiosis. He submits that the chest x-rays were negative for simple or complicated pneumoconiosis and there was no positive biopsy evidence of pneumoconiosis. Additionally, he submits that there were no pulmonary function studies or blood gas studies that satisfy the regulatory requirements for total disability.

Counsel argues that the medical reports demonstrate no pneumoconiosis and that Dr. Rasmussen's opinion of legal pneumoconiosis is improperly based upon a diagnosis of simple chronic bronchitis and not upon objective medical findings. He submits that the Claimant is not totally disabled and the claim should be denied.

II. Summary of relevant evidence:

Testimony of Claimant (TR 9 through 31)

On direct examination the Claimant testified that he is 5'7" tall, weighs his normal weight of 190 pounds and was born on April 17, 1939. He reported that he is married and that his wife is his sole dependent. He reported being a high school graduate with additional job training at the Mine Safety and Health Administration. He testified that he smoked cigarettes approximately five to six years before stopping in 1969.

The Claimant testified that he began working in the coal mines during the evening shift while going to high school in 1957. He worked at the Cutshin Coal Company ditching water, setting posts, and his primary job of loading coal with a number 4 red-edge shovel. The shovel load weighed about 45 pounds and would generate coal dust on a daily basis when the coal was dry, which was half the time. After high school graduation he went to work for Lewis Brothers Coal Company loading, drilling and shooting coal. Drilling coal was dusty and shoveling coal was dusty when the coal was dry. The drill used was a 90 pound two-man drill. After the hole was drilled, it was shot with air through a 2-inch hose to break the coal. He was with Lewis Brothers Coal Company to 1959 and then went to Liberty Coal Company where he was a coupler on a gathering motor. He reported this work entailed coupling 3-ton coal cars together at the face and pulling them from the mine to the tipple area for dumping. At the tipple area a bar was used on the cars to release the coal into the hopper which created coal dust every time.

The Claimant testified that after Liberty Coal Company, he went to work for Kentucky Mountain Coal Company running the gathering motor where he didn't have to drop pins to couple the coal cars together. He was there for three years and then went to Blue Diamond Coal Company in 1962 where he worked for nine years. He started at Blue Diamond Number 2 mine as a motorman and supply man. When Blue Diamond number 2 shut down he transferred to Blue Diamond number 1 where he pumped water until 1964 when he made working foreman at the face area. He supervised the face area with all the other men and was exposed to the same coal dust. As a working foreman, he would spell his people out during dinner and perform their jobs during their dinner break.

The Claimant reported he left Blue Diamond and went to the U.S Bureau of Mines from 1971 to November 1974 as a coal mine inspector. The inspecting job involved about four hours in the mine, four days a week, inspecting the face, return air courses and belt lines. In 1974 he went to Johnson Coal Company as a foreman where he was exposed to coal dust three to four days a week when he was in the face area. At Johnson Coal Company he would spell miners during change out. After Johnson Coal Company, he worked 17 years for the Mine Safety and Health Administration (MSHA). The last 10 years with MSHA he was a health specialist and took dust samples and noise surveys at the face area. Work with MSHA also involved working the return air courses, the belt lines, and the air intake equipment in addition to the face area. On an average he would be exposed to dust four days a week. Other than walking, the inspection work did not involve heavy manual labor. He retired from mine inspection in January 4, 2004. From high school to retirement, all his work was in coal mining and coal mine inspection.

The Claimant testified that he quit work with MSHA because he had trouble breathing and could not do his job under ground, he could not carry his equipment, and couldn't walk underground sufficiently. He stated he had a hard time breathing the last four to five years, has been short of breath, and has difficulty walking up a flight of stairs without breathing hard. He reported that he walks a lot, but not fast, and could probably walk 100 yards on level ground at his pace. He reported difficulty walking up a grade and trouble lifting things. He stated that he will sit in a chair to go to sleep and then go to bed and use two pillows. He reported dry coughing every night but no medication for the cough. He reported going to the emergency room for oxygen two or three times in the past seven or eight years; but no trips this year.

The Claimant testified that he is a diabetic, had a couple of heart attacks, and has a stent. He reported that his breathing has become worse and that he could not go back to underground coal mining.

On cross-examination, the Claimant testified that he worked for MSHA from February 14 or 16, 1988 through January 4, 2004. He reported working for the federal government three times, with the last job with MSHA being the longest. The total time working for MSHA and the US Bureau of Mines was twenty years and four or six months. He stated that in 2005 he had filed a claim under the Federal Employee Compensation Fund for hearing loss and that the claim had been denied. He reported that he did not file a claim under the Federal Employee Compensation Act for any other medical problem, including black lung disease.

The Claimant testified that his family doctor is Dr. J. Prater and that Dr. Prater told him to stop work and sign up for Social Security and black lung (benefits). He reported one heart attack around 2002 or 2003 during which time a stent was inserted and his second heart attack in May, 2006.

The Claimant testified that in the past he was an owner/operator of Southern Hills Mining Company, DFJ Coal Company and Great Southern Mining. He reported being a manager for Johnson Coal Company and the President of Southern Hills Mining Company. He stated that he worked forty hour weeks for the federal government and eighty to ninety hours a week running a coal mine.

Upon questioning by the Administrative Law Judge, the Claimant testified that the sequence of mine companies was Blue Diamond mines from 1971 to 1974, then Johnson Coal Company, then Southern Hills Mining, and then to MSHA. He stated that the same people were partners in Johnson Coal, Southern Hill and Great Mining.

Deposition testimony of Claimant (DX 17)

On March 28, 2005, the Claimant was deposed by counsel for the Parties. The Claimant testified to his age, address, and work history in a manner consistent with his hearing testimony. He testified that his family doctor is Dr. J. Prater of Hazard, Kentucky. He reported that Dr. Prater requested he leave the mines in 2003 because of his heart attack and that no doctor has told him that he is disabled from black lung disease.

The Claimant testified that he had heart surgery with stent placement following a November 2003 heart attack. He reported he is diabetic for about four years and takes medicine for cholesterol. He reported breathing problems sometimes and a few trips to the emergency room because of breathing problems; but no such trips in the last couple of years. He reported that he stopped smoking cigarettes in 1969. He stated that he is to receive a federal retirement check for his mine inspector work and that he receives retirement benefits under the Social Security Act.

On cross-examination, the Claimant testified that the breathing problems he would experience were "smothering" and sometime cough. When he has these breathing problems he can't work long, maybe an hour or two, and has to pace himself. He testified that he sees Dr. Prater every three months and once was placed on pills for his breathing but quit taking them because it seemed to make things worse and quit using an inhaler because it didn't help.

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b). Larger and more numerous opacities result in greater lung impairment.

The following table summarizes the x-ray findings available in this case. Physicians' qualifications appear by footnote after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations of record.[5] Readers who are

[5]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are

board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

	Exhibit No.	X-ray Date	Physician	Reading	Quality
OWCP	DX 12	4/20/05	D. Rasmussen[6]	4/22/05 – 0/1, s/s, O Scattered calcified granuloma, Bilateral mild eventation of the diaphragms	1

Claimant's initial reliance (ALJX 2): no additional documentary evidence submitted.

Employer's rebuttal (ALJX 3):

DX 28	4/20/05	D. Halbert[7]	7/13/05 – 0/0, O No parenchymal abnormalities consistent with pneumoconiosis No pleural abnormalities consistent with pneumoconiosis No costophrenic angle obliteration No other abnormalities	2

Employer's initial reliance (ALJX 3):

DX 26	4/14/05	A. Dahhan[8]	4/14/05 – 0/0[9]	1
EX 1	4/14/05	D. Halbert[10]	6/5/05 – 0/0, O No parenchymal abnormalities consistent with pneumoconiosis No pleural abnormalities consistent with pneumoconiosis No costophrenic angle obliteration No other abnormalities	1

Claimant's rebuttal (ALJX 2): no rebuttal evidence submitted.

Biopsies

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designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination.

[6] B-reader 10/1/2000 to 9/30/2004 (CX 1)
[7] B-reader 7/1/1986 to present (DX 28 at 5)
[8] B-reader 4/1/2005 to 3/31/2005 (DX 26 at 18)
[9] ILO classification in written report. Required chest x-ray report form not completed beyond film quality.
[10] B-reader 7/1/206 to 6/30/2010 (EX 1 at 6)

Biopsies may be the basis for a finding of the existence of pneumoconiosis. No biopsy reports were submitted for consideration.

Autopsies

An autopsy may be the basis for a finding of the existence of pneumoconiosis. The Claimant is alive therefore there is no autopsy evidence.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must first be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and then either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i). For the purposes of the tables in Appendix B of Part 718, this Administrative Law Judge finds the Claimant to be 66.5" tall[11] and 66 years of age when the pulmonary function studies were performed. Based on the Claimant's age and height, the reported FEV1 results are above the Table B FEV1 1.68 requirement, such that neither of his pulmonary function studies qualify to establish total disability.

Exhibit No.	Study Date	Physician	FEV1	FVC	FEV1/FVC	MVV
OWCP DX 12	4/20/05	D. Rasmussen	pre: 3.50	pre: 4.60	76.0%	

Claimant's initial reliance (ALJX 2): no additional documentary evidence submitted.

Employer's rebuttal (ALJX 3): no rebuttal evidence submitted.

Employer's initial reliance (ALJX 3):

DX 26	4/14/05	A. Dahhan	pre: 3.0	pre: 3.88	77.0%	41

[11] Dr. Rasmussen reported the height as 66.5" (DX 12). The technician performing clinical studies for Dr. Rasmussen recorded the Claimant's height as 67" (DX 12). Dr. Dahhan reported the height as 65-3/4" (DX 26). The technician performing the clinical studies for Dr. Dahhan recorded the Claimant's height as 65" (DX 26). The Claimant testified he was 67" tall (TR 9). The treating physician did not record a height in the Claimant's treatment records (DX 11).

Claimant's rebuttal (ALJX 2): no rebuttal evidence submitted.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b).

	Exhibit No.	Study Date	Physician	PCO2	PO2	Altitude
OWCP	DX 12	4/20/05	D. Rasmussen	32.0 (rest) Resting b/g normal 34.0 (exercise) Poor exercise tolerance due to right lower extremity Oxygen transfer normal No significant loss of lung function	81.0 (rest) 82.0 (exercise)	<3000 feet

Claimant's initial reliance (ALJX 2): no additional documentary evidence submitted.

Employer's rebuttal (ALJX 3): no rebuttal evidence submitted.

Employer's initial reliance (ALJX 3):

DX 26	4/14/05	A. Dahhan	37.3 (rest) Moderate hypoxia at rest 36.8 (exercise) Normal exercise values	62.3 (rest)[12] 81.3 (exercise)	

Claimant's rebuttal (ALJX 2): no rebuttal evidence submitted.

[12] This resting study indicates "total disability" pursuant to Table 1 of Appendix C of Part 718. The examining physician attributed the resting hypoxemia to the Claimant's cardiac condition (DX 26).

Other Medical Evidence

Medical records related to medical treatment, and hospitalization for treatment, of a respiratory or pulmonary or related disease are generally relevant and may be received into evidence regardless of the evidentiary limitations placed upon a claimant and respondent under 20 CFR § 725.414(a)(2) and (a)(3). see 20 CFR § 725.414(a)(4)

(DX 11) Dr. J. Prater, M.D., treatment records for the period 1/19/04 to 4/1/05 are listed for consideration by the Claimant (ALJX 2). Review of the medical treatment records indicate that the majority of the doctor visits were for checkups of his diabetes, coronary artery disease – status post stent, cholelithiasis, history of myocardial infarct, history of deep vein thrombosis, vertigo, depression and anxiety. Only the following portions relate to "a respiratory or pulmonary or related disease" such that they may be considered as evidence.

September 28, 2001 chest imaging for complaints of chest pain and shortness of breath. The examining physician, Dr. M. Pampati, M.D., reported "evidence of calcified hilar nodes. There is also evidence of fullness in the right hilar region. Left lung is unremarkable. No evidence of pleural effusion or pneumothorax. There is not shift." His impression was "Lymph nodes in the carina area cannot be excluded." A CT angiography of the chest was performed the same date and Dr. Pampati reported "evidence of multiple lymph nodes in the aorticopulmonary window area, carinal area as well as in the precarinal space. There is also a lymph node seen in the right hilar area. Bronchoscopic evaluation may be helpful." His impression was "No evidence of [pulmonary embolism] based on this exam. Lymph nodes in the carinal area as described above as well as in the right hilar area."

Follow-up imaging of the chest on September 30, 2003 reported "There is a tiny 3 mm pulmonary nodule, which was present in the previous study in [September 28,] 2001 and it has remained stable, partially overlying the anterior aspect of the right 4th rib. There are no pulmonary infiltrates or pleural effusions identified." The impression included "No pulmonary nodules, infiltrates, or pleural effusions have developed when compared with the previous studies obtained in 2002 and 2001.

During routine examinations on January 19, 2004, June 25, 2004, October 1, 2004, the Claimant denied shortness of breath as a complaint.

Medical Reports

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work

histories. 20 CFR § 718.202(a)(4). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv). With certain specified exceptions, not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2005). A determination of the existence of pneumoconiosis can not be made solely on the basis of a living miner's statements or testimony 20 CFR § 718.202(c).

The record contains the following medical opinions relating to this case.

(DX 12) On April 20, 2005, Dr. D.L. Rasmussen, M.D., independently examined the Claimant on behalf of the Department of Labor. He recorded the Claimant's complaints as "shortness of breath with exertion about ten years ago … significant dyspnea after climbing two flights of stairs … chronic, mostly morning productive cough … wheezes with exertion … sleeps on two pillows … some [right leg] swelling … snores and breathes hard … sleepy during the day … [and] substernal discomfort occasionally and also bilateral lower posterior chest discomfort at times." Smoking history was recorded as being from 1964 to 1969. Medical history included thrombophlebitis in the right lower extremity in the 1970's and recurrence in 2001, myocardial infarction in 2002 with development of staphylococcal septicemia, syncope, vertigo in 2004, and depression treated with Paxil. Other medications included aspirin, Metformin, Lescol, Warfarin for blood clots, Amaryl, and Hydrochlorothiazide. Work history was reported as a mine inspector for the Mine Safety & Health Administration from 1988 to January 4, 2005, as a health, dust and noise inspector requiring underground coal mine walking and crawling 3-4 days each week; three years as an inspector with the U.S. Bureau of Mines (1971-1974); and coal miner from 1957, starting as a hand loader and progressing through track motor operator, brakeman, roof bolter, continuous miner, shuttle car operator and section foreman.

Physical examination reported the Claimant as 66.5" tall, 177 pounds weight and blood pressure at 104/62. Chest expansion and diaphragmatic excursions were normal. Breath sounds were moderately reduced with bilateral basilar crackles. No rhonchi or wheezing was noted. Heart tones were "quite reduced" with regular rhythm and no murmurs, gallops or clicks. Peripheral pulses were intact with no edema or clubbing. His right lower extremity was larger than the left.

Dr. Rasmussen reported the chest x-ray as indicating "pneumoconiosis s/s with a profusion of 0/1 throughout three zones on the right and the lower two zones on the left … [with] calcified granulomata scattered throughout and bilateral mild evantration of the diaphragms" Ventilatory function studies and resting blood gases were normal. The single breath carbon monoxide diffusing capacity was mildly reduced. An incremental treadmill exercise test indicated "poor exercise tolerance, due probably in part to the patient's right lower extremity post phlebitis syndrome … [however] no significant loss of lung function … [and retention of] the pulmonary capacity to perform his last regular coal mine job."

Dr. Rasmussen opined that the Claimant "has a very significant history of exposure to coal mine dust … has insignificant x-ray changes to justify a diagnosis of coalworkers' pneumoconiosis … [the] coal mine dust exposure has caused no significant loss of lung function … [and] has insufficient evidence to justify a diagnosis of medical coalworkers' pneumoconiosis. Nonetheless, he has legal pneumoconiosis (simple chronic bronchitis caused by his coal mine dust exposure), but with non-disabling and insignificant loss of lung function." Dr. Rasmussen also diagnosed heart disease and sleep apnea as non-occupational cause factors.

Dr. Rasmussen received his MD in 1952 and is a specialty board member with the American Board of Internal Medicine, American Board of Forensic Examiners, and American Board of Forensic Medicine. He is a Fellow with the American College of Forensic Examiners and a Senior Disability Analyst and Diplomate with the American Board of Disability Analysts. He is a NIOSH B-reader with certification from October 1, 2000 until September 30, 2004. He has been involved within the field of pulmonary medicine continuously since January 1960. He has been widely published in the field of pulmonary disease of coal miners for nearly 40 years. (CX 1)

(DX 26) The Employer submitted to the Director the April 20, 2005 medical report of Dr. A. Dahhan, M.D., related to his examination of the Claimant on April 14, 2005. The occupational history recorded did not reflect work as a mine inspector and recorded 11 years credit for mine work out of a claimed 20 years of mine work as a mine operator, mine superintendent and part owner of a mine. The Claimant reported a history of occasional cough with clear sputum, intermittent wheeze, dyspnea on exertion such as a flight of stairs, and medication for hypertension, high lipids, and medication for diabetes and blood thinners. He denied bronchodilators. He reported a heart attack in 2002 with stent placement. On examination, the Claimant was 65-3/4 " tall, weight at 181 pounds and blood pressure of 110/80. His chest had good air entry to both lungs with no crepitation, rhonci or wheeze. Cardiac examination revealed a regular rhythm with occasional PVCs. No gallops or murmurs were heard. The extremities were without clubbing or edema and with peripheral pulses.

Dr. Dahhan reported clinical testing as: electrocardiogram indicated occasional PVCs with evidence of an old inferior wall myocardial infarct; blood testing revealed carboxyhemoglobin level at .2%; arterial blood gases at rest with moderate hypoxia with PO2 at 62.3 and PCO2 at 37.3, exercise testing showed normal PO2 of 81.3 and PCO2 of 36.8; spirometry showed normal lung volume, normal respiratory mechanics, normal FVC of 3.88 liters which was 97% of predicted value, and FEV1 of 3.0 liters which was 96% of predicted value, diffusion capacity was normal at 97%; and chest x-ray was clear with no pleural or parenchymal abnormalities consistent with pneumoconiosis.

Dr. Dahhan opined that there were "insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis based on normal clinical examination of the chest [and clinical testing] … no objective findings to indicate total or permanent pulmonary disability … from a respiratory standpoint [the Claimant] retains the physiological capacity to continue his previous coal mining work or job of comparable physical demand [and, the Claimant] has coronary artery disease, which has caused him to have resting hypoxemia, a condition of the general public at large and is

not caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

Dr. Dahhan has practiced medicine from 1964 and specializes in internal medicine – pulmonary. He was certified by the American Board of Internal Medicine in 1975 and the American Board of Pulmonary Medicine in 1982. He is a Fellow of the American College of Chest Physicians and a certified B-reader. He is published several times in the area of pulmonary diseases.

(DX 29) The Employer submitted for consideration the July 22, 2005, medical opinion of Dr. B.T. Westerfield based on the medical record review of "medical evidence from the US Department of Labor and the respiratory evaluation of Dr. D.L. Rasmussen." Dr. Westerfield did not further identify the documents reviewed not did he examine the Claimant, chest x-rays or CT scan. Dr. Westerfield opined that there was "no evidence of radiographic pneumoconiosis" in the Claimant based on his notation that Dr. Pampati and Dr. Berje found no evidence of pneumoconiosis and Dr. Rasmussen read a chest x-ray as negative for pneumoconiosis. He further opined that "there is no evidence that [the Claimant] has any chronic lung disease or experiences any impairment related to his coal mine employment. In fact, there is no evidence that [the Claimant] has any respiratory disease at all. ... there is no evidence from a primary physician that he is treated for a respiratory disease … pulmonary function studies which include spirometry and arterial blood gasses are completely normal … [and his] history of heart disease and his cardiac disease as well as his overall deconditioning may explain his shortness of breath." Dr. Westerfield opined that the Claimant "has completely normal lung function" and that medical evidence available does not support "any chronic pulmonary disease or respiratory impairment that could be attributed to, caused by, or aggravated by [Claimant's] coal dust while employed in coal mining." Dr. Westerfield opined that "there has been no respiratory injury to [the Claimant] that would be attributable to inhalation of coal dust either causing pneumoconiosis, obstructive lung disease or chronic obstructive pulmonary disease." It is specifically noted that Dr. Westerfield did not list or otherwise identify the medical records reviewed in sufficient detail to determine if Dr. Westerfield's opinion is based on all the evidence of record available by July 22, 2005, or was based on selectively culled records or records not submitted for consideration by the Parties. Accordingly, little weight is granted to Dr. Westerfield's opinions that are not directly tied to specific documents of record.

DISCUSSION OF LAW AND FACTS

I. Jurisdiction and Applicable Laws

The evidence establishes that the Claimant worked as a coal miner for 26-2/3 years (from mid-1957 to 1971 and 12/1974 to 2/14/1988). An as a coal mine inspector for 20-3/4 years for the U.S. Mine Safety & Health Administration (2/15/1988 to 1/4/2005) and the U.S. Bureau of Mines (in 1971 to 11/1974). The last employment as a coal miner was for approximately 8 months with the Kentucky Prince Mining Company in late-1987 to early-1988. Prior to Kentucky Prince Mining Company, the Claimant worked as a miner for the Southern Hills

Mining Company from the end of 1985 to mid-1987.[13] The qualifying coal miner work and the coal mine inspector work were in the coal mines of Kentucky. Accordingly, this claim is governed by the law of the U.S. Court of Appeal for the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

In addressing a black lung benefit claim by an individual with a history of coal miner and mine inspection work, the U.S. Court of Appeals for the Sixth Circuit has held that "the federal government cannot be a responsible operator because it is immune from liability for claims brought under the Black Lung Benefits Act." *Eastern Associated Coal Corp., v. Director, OWCP*, 791 F.2d 1129 (6th Cir. 1986)[14] The Court also stated, at 791 F.2d 1131, that the particular claimant's "exclusive remedy is to file a claim under the Federal Employees Compensation Act [FECA]. See 5 USC § 8116(c) (1982)." The Court further mentioned the "election of remedies doctrine" in the unreported case of *Wolf Creek Colliers v. Sammons*, 142 Fed. Appx. 854 (6th Cir. 2005), when it found that the deceased was working as a mine inspector at the time of his death from an explosion and mine collapse and that the events of his death were separate from the occupational injury of black lung disease so that the decedent's widow could pursue separate claims under the FECA and BLBA for the separate injuries. However, the Court paid no attention to any election of remedy doctrine under the FECA, in addressing black lung disease benefits for former coal miners who finally worked as coal mine inspectors, in the unpublished cases of *Church v. Bebe Coal Corporation*, 10 Fed. Appx. 320 (6th Cir. 2001); of *Mills v. Island Creek Coal Company*, 902 F.2d 33 (6th Cir. 1990); and the published case of *Tussey v. Island Creek Coal Company*, 982 F.2d 1036 (6th Cir. 1993).

The U.S. Court of Appeals for the Fourth Circuit has addressed the issue of election of remedies for a coal mine inspector with a long history of coal mine employment who filed a claim for black lung benefits. The Court held that "while the FECA does include an election of remedies section, see 5 U.S.C. § 8116(b), this provision only restricts a claimant's choice of remedies against the federal government, not his choice of remedies as between the federal government and a private employer." *Consolidated Coal Company v. Borda*, 171 F.3d 175 (4th Cir. 1999) The Court continued, at 171 F.3d 180, to state that the respondent employer "has misconstrued the impact of *Eastern Associated Coal Corp. v Director, OWCP ("Patrick"),* 791 F.2d 1129 (4th Cir. 1986) and *Kopp v. Director, OWCP*, 877 F.2d 307 (4th Cir. 1989), which mandate only that if a federal employee wishes to seek compensation from the federal government for pneumoconiosis, FECA is his exclusive remedy because Congress did not waive the federal government's sovereign immunity in enacting the Black Lung Benefits Act. … These cases do not support the proposition that the federal government precedes a private employer in the hierarchy of a claimant's potential compensation sources. … the miner is free, consistent with the purposes of the Black Lung Benefits Act, to attempt to maximize his benefits by choosing to seek compensation first, or even exclusively, under the more generous statutory scheme."

[13] DX 3 and 12 lists the same work history from Claimant. DX 8 is the Social Security Administration report of earnings for the period from 1978. DX 17 contains Claimant's deposition testimony on his work history. The Claimant's hearing testimony is at TR 11-23 and 26-31. The period of work as a mine inspector in non-government coal mines is not considered as coal mine employment for purposes of the BLBA

[14] The Court noted in footnote #2 that the issue of whether an inspector can be a miner and whether the federal government could be a mine operator were not addressed since the issues did not affect the outcome of the case which was a grant of benefits and placement of liability on the Appellant responsible operator.

The views of the U.S. Court of Appeals for Sixth and Fourth Circuits are not in conflict. Both hold that the federal government is immune from liability under the BLBA, a federal mine inspector may seek benefits from the federal government under the FECA, and a federal mine inspector may seek benefits from a private coal mine company under the BLBA. Accordingly, the Respondent's proposition that the federal government was the Claimant's last responsible employer under the BLBA and that the Claimant must first seek benefits from the federal government under the FECA is without merit. Thus this Administrative Law Judge finds that the Claimant has properly filed a claim under the BLBA seeking benefits from the last non-government employer for which the Claimant performed qualifying coal mine employment.

II. Status as Miner and Responsible Operator

The 1977 amendments state that the purpose of the BLBA is to provide benefits, in cooperation with the states, to miners who are totally disabled due to coal workers' pneumoconiosis, and to surviving dependents of miners whose death was due to such disease. 30 U.S.C. § 901(a). Thus, a prerequisite to establishing entitlement to benefits is proving that the claim is on behalf of a coal miner or a survivor of a coal miner.

The Parties have stipulated that the Claimant was a miner under the BLBA while employed with Southern Hills Mining Company, Inc.. The record establishes that Southern Hills Mining Company was the last non-government coal company to employ the Claimant for a cumulative period of not less than one year. (DX 3, 8, 12 and 17; TR 11-23, 26-31) Accordingly, the Respondent Employer is the responsible operator under the BLBA.

IV. Length of Employment

As noted above, the Claimant has established that he worked as a coal miner for 26-2/3 years (from mid-1957 to 1971 and 12/1974 to 2/14/1988) and as a coal mine inspector for 20-3/4 years for the U.S. Mine Safety & Health Administration (2/15/1988 to 1/4/2005) and the U.S. Bureau of Mines (in 1971 to 11/1974).

DISCUSSION OF MEDICAL EVIDENCE

The regulations at 20 CFR § 718.201 define pneumoconiosis broadly:

> (a) For the purpose of the BLBA, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal

workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*). 20 CFR § 718.202(a) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. Here there is no evidence that the Claimant has had a lung biopsy, and, of course, no autopsy has been performed since he is still living. None of physicians reading the Claimant's chest x-rays and/or examining the Claimant and/or his medical records have reported the existence of either complicated pneumoconiosis or simple pneumoconiosis.[15] The Claimant is not entitled to any of the presumptions provided under 20 CFR §§ 718.304, 718.305 or 718.306

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

[15] See DX 12, 26 and 28; EX 1 as noted herein

The Claimant may establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2005). In *Eastover Mining Co. v. Williams*, 338 F.3d 501, 513 (6th Cir. 2003), the Sixth Circuit has interpreted this rule to mean that "in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts."

In this case, the Claimant's medical records indicate that he was examined once, on April 20, 2005, by Dr. Rasmussen at the request of the Department of Labor. Dr. Rasmussen found "insufficient evidence to justify a diagnosis of medical coalworkers' pneumoconiosis. Nevertheless, he has legal pneumoconiosis (simple chronic bronchitis caused by his coal dust exposure) but with non-disabling and insignificant loss of lung function." (DX 12) It is noted that forms of chronic obstructive pulmonary disease can be encompassed within the definition of

legal pneumoconiosis if the chronic obstructive pulmonary disease was caused by coal mine dust. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

Six days before Dr. Rasmussen's examination, the Claimant was examined by Dr. Dahhan who found no objective findings of any pulmonary disease that could have been attributed to coal mine dust exposure. There were no moderately reduced breath sounds or bilateral basilar crackles, as reported by Dr. Rasmussen, and the recorded resting hypoxemia (which met the threshold requirements for "total disability" under Table 1, Appendix C, Part 718) was attributed by Dr. Dahhan to the Claimant's arterial disease.

Unlike Dr. Rasmussen, Dr. Dahhan appeared to only know half the Claimant's coal mine history and was unaware of the mine inspector work. Both Dr. Rasmussen and Dr. Dahhan reported the Claimant's medication list as not including a bronchodilator. Dr. Rasmussen recorded a ten year history of shortness of breath; however, this is clearly contradicted by the Claimant's treating physician medical records and the Claimant's deposition testimony. The Claimant's treating physician, Dr. J. Prater, M.D., had the Claimant examined following complaints of shortness of breath in September 2001. Dr. Pampati read the September 28, 2001, chest x-ray as demonstrating calcified hilar nodes and fullness in the right lung hilar region. The left lung was unremarkable. A CT scan the same day indicated multiple lymph nodes in the aorticopulmonary window area, carinal area and the precarinal space with one lymph node in the right lung hilar area. Dr. Pampati also reported the September 2003 follow-up chest x-ray showed no change from the September 2001 chest x-ray, including the tiny 3 mm pulmonary nodule overlying the right 4th rib. It is noted that Dr. Prater's treatment records show that the Claimant denied shortness of breath during subsequent examinations. (DX 11)

Finally, Dr. Rasmussen failed to set forth his rationale for the diagnosis of "simple chronic bronchitis caused by coal mine dust exposure" which is the sole basis of his statement that the Claimant "has legal pneumoconiosis … with non-disabling and insignificant loss of lung function." After consideration of the evidence of record, the qualifications of the respective physicians, and the professional relationship of the physicians to the Claimant, this Administrative Law Judge finds that Dr. Rasmussen's blanket statement "he has legal pneumoconiosis (simple chronic bronchitis caused by coal mine dust exposure)"[16] not be a well-reasoned medical opinion. Accordingly, it is given no weight. There is no other sound medical opinion that the Claimant has either clinical or legal pneumoconiosis. Also, there are no well-reasoned medical opinions that the Claimant has any significant restrictive or obstructive lung disease related to coal mine dust exposure that results in total disability.

After deliberating on all the evidence of record, this Administrative Law Judge finds that the Clamant has failed to meet his burden of showing that he has a pulmonary or respiratory disease attributable to his exposure to coal mine dust. Thus he is not entitled to benefits under the BLBA.

CONCLUSIONS AND FINDINGS OF FACT

After deliberation on all the evidence of record, this Administrative Law Judge finds that:

[16] at DX 12 pages 33 and 34

1. The Claimant has 26-2/3 years of work as a coal miner in and around one or more coal mines.

2. The Claimant has 20-3/4 years of work as a coal mine inspector for federal government agencies.

3. The Respondent Employer was the last non-governmental coal mine operator who last employed the Claimant as a coal miner for a cumulative period of at least one year and is thus the responsible operator under the BLBA.

4. The Claimant has failed to establish that he has pneumoconiosis as defined by the BLBA and regulations.

5. The Claimant has failed to establish that he has pneumoconiosis arising out of his coal mine employment.

6. The Claimant has failed to establish that he is totally disabled due to pneumoconiosis.

7. The Claimant is not entitled to benefits under the BLBA.

ORDER

IT IS HERBY ORDERED that the claim for benefits filed on January 28, 2005, is hereby **DENIED.**

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ALAN L. BERGSTROM
Administrative Law Judge

ALB/jcb
Newport News, Virginia

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, this Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).